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THE (MIS)MANAGEMENT OF MEDICARE

During a recent congressional hearing on Medicare reform, a Member in attendance said: "[U]sing managed care to solve Medicare's problems is like going to Saddam Hussein to find out how to teach democracy." The statement – reflecting a common disenchantment with health maintenance organizations [HMOs] – implies that Medicare's current fee-for-service program is itself free of the faults of managed care.

Not everyone would agree. Last year, a number of witnesses testifying to the House Budget Committee Task Force on Health contended that Medicare's complex billing and regulatory schemes can actually influence the decisions doctors make in treating their patients. This, coupled with the increasingly close scrutiny by the program's administrators – specifically the Health Care Financing Administration [HCFA] – led one witness to say: "The sense of intimidation and fear of HCFA among physicians is widespread and troubling."

Such concerns matter because Medicare reform – for which the House budget resolution sets aside $153 billion over the next 10 years, with access to additional resources if needed – could be an expensive failure if Congress misses the opportunity to make Medicare a better program, not just a more solvent one.

HMOs are unpopular because their efforts to control costs sometimes affect patient care, and not always for the better. But conventional Medicare suffers its own problems. Medicare's benefits seem consistently to lag behind modern medicine, as evidenced by its lack of coverage for prescription drugs and catastrophic costs. Consequently, beneficiaries need other supplemental forms of coverage; on average, Medicare only covers around half of a beneficiary's costs. Moreover, a recent report by the Lewin Group found that it takes between 15 months and 5 years to add new technologies to the Medicare Program.

HCFA's excessive regulations also affect physician practice. The Mayo Foundation says there are more than 110,000 pages of Medicare regulations and supporting documents, and some interpretations of them contradict others. The result: doctors are forced to take time away from patient care to deal with Medicare's rules – and then may still be left wondering whether they have complied.

Medicare's complexity also is wasteful. Says Uwe E. Reinhardt, professor of political economy at Princeton University: "[T]he statutes and rules governing Medicare . . . now run the risk of becoming themselves a form of waste, fraud, and abuse." Yet despite all these rules, improper fee-for-service Medicare payments totaled $11.9 billion in fiscal year 2000 – and the measure used to detect them is not even designed to identify fraud.

One alternative is the proposal of the Bipartisan Medicare Commission. It would empower *beneficiaries* to manage their own care by choosing health plans best suited to their needs, whether fee-for-service, HMO, or some other option. It also would allow private plans to bid on Medicare services for a market price – unlike the current Medicare+Choice, in which plans receive a predetermined administered payment that can lead to both underpayments and overpayments. Although the Commission plan is only one alternative, its principles warrant consideration.

An approach such as the Commission's would help improve Medicare's long-term financial condition. But it would do more: it would help restore the role of doctors and patients – rather than government regulators – as the ultimate decision makers in beneficiary care.

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